



Pioneer Assurance Company Limited

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**STRICTLY CONFIDENTIAL
MEDICAL EXAMINATION REPORT**

FULL NAME: _____	MARITAL STATUS _____.
DATE OF BIRTH: _____	SEX _____.
OCCUPATION: _____.	

PART 1

a) Have you satisfied yourself with the identity of the applicant? YES NO				
b) Applicants identification:	ID CARD	PASSPORT	BIRTH CERT	DRIVING LICENCE
NUMBER				

**IF THE APPLICANT IS NOT ABLE TO PROVIDE SATISFACTORY IDENTIFICATION
PLEASE DO NOT PROCEED**

PART 2

The following questions are to be asked by the medical examiner and answered by the applicant.

Have you ever suffered from any of the following	YES/NO	If answering 'yes' to any of the questions, please give full details including dates
1. a) Bronchitis, Asthma or any other lung condition?		
b) Anxiety, depression, nervous breakdown, or any other nervous or mental disorder?		
c) Angina, heart attack, hypertension, rheumatic fever, valve problem, or any other heart disorder?		
d) Stomach, bowel, liver or gallbladder disorder?		
e) Attacks of arthritis or gout?		
f) Diabetes, kidney, bladder or any other urinary disorder?		
g) Enlarged glands, growths, tumors or cancers?		

h) Cerebellar vascular accident or neurological disorder?				
i) Any significant disease or injury not mentioned above?				
2.				
a) Have you ever undergone any surgical operations X-rays, investigations or blood tests?				
b) Are you taking any form of drugs?				
c) Have you ever: received treatment for high blood pressure?				
3.				
a) Have you ever had an AIDS blood test?				
b) Have you ever received medical advice, counseling or treatment in connection with AIDS or any other sexually transmitted diseases including hepatitis B?				
4.				
a) Have you ever taken drugs other than for medical purposes?				
5.		Beer	Wine	Spirits
a) Do you consume alcohol? If so, how regularly and in what form				
b) Do you smoke? If so, how much and in what form		Cigarettes	Cigars	Tobacco

PART 3 FAMILY HISTORY

FAMILY RELATIONSHIP	IF LIVING		IF DEAD	
	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHERS				
SISTERS				
a) Have any of the above ever had a heart disease, hemophilia, kidney disease, mental disorders or any hereditary condition?				
b) Is the heart enlarged?				
c) Is there any abnormality of the heart sounds or murmurs present? If murmur found, state whether functional or organic in origin?				

<p>Signed in my presence at _____</p> <p style="text-align: center;">this ____ day of _____ 20__</p> <p style="text-align: center;">_____ Medical Examiner</p> <p>Full Name _____</p>	<p>I certify that my answers to the foregoing questions and statements are correct and form part of my application for insurance. I hereby authorize any and every Doctor who has attended me, or may hereafter attend me, or whom I have consulted, or may hereafter consult, to disclose in evidence upon oath or in writing at any time and from time to time all information which he may in any manner have acquired.</p> <p style="text-align: center;">_____ Signature of Applicant (Applicant should be there in presence of Medical Examiner)</p>
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PART 4 PULSE

a) Measure rate and describe character?
b) What is the state of the arterial walls?
c) Is there any vascular abnormality in the legs or reduced foot pulse?

PART 5 BLOOD PRESSURE

If the first reading exceeds 140 systolic or 90 diastolic (5 th phase), please take 2nd and 3rd readings at 5minutes intervals

	1 ST READING	2 ND READING	3 RD READING
Systolic			
Diastolic (4 th phase)			
Diastolic (5 th Phase)			
Pulse Rate			

PART 6 URINE

a) Is albumen present?
b) Is sugar present?

I declare the aforementioned statements are true to the best of my knowledge and belief and I agree that shall form part of my application for life assurance.

Examiner's signature _____

Date: _____

PART 7 MEDICAL EXAMINATION

Answers to be given by doctor. Please give details where appropriate

1. MEASUREMENTS

HEIGHT	WEIGHT	CHEST		ABDOMEN
		At full inspiration	At full Expiration	At the umbilicus

a) Does the weight appear constant, increasing or decreasing?

b) Describe the general build and appearance?

c) Does the appearance correspond with the stated age?

d) Is there any evidence of intemperate habits?

2. RESPIRATORY SYSTEM

a) Is the chest well developed and does it expand freely?

b) Are there any normal physical signs?

3. HEART

a) Is the position of the apex beat normal?

b) Is it unduly forceful?

c) Is blood present?

d) Any other abnormalities?

4. ABDOMEN

a) Is there any evidence of past or present digestive trouble or disorder of :

i) The Liver

ii) The Spleen?

iii) The stomach

Iv) The bowels

b) Is there hernia present?

8. NERVOUS SYSTEM

- a) Are the pupil reactions normal?
- b) Are the knee and ankle reflexes normal?
- c) Are speech, memory and sight normal?
- d) Is there evidence of an ear disorder or hearing impaired?
- e) Is there evidence of any disease of the central nervous system?

ADDITIONAL INFORMATION

Please elaborate on any relevant answers given by the examinee and any abnormal findings where significant. Please attach an additional sheet if necessary.

Medical examiner's full name and qualifications (BLOCK LETTERS PLEASE)

Signature

Full address to which fee will sent

Name:

Address:

Tel/Fax:

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